by vesicles followed by pustules. It can be distinguished from varicella by an eschar at the site of the mouse-mite bite and the papule/plaque base of each vesicle. *Acute generalized eruptive pustulosis* should be considered in individuals who are acutely febrile and are taking new medications, especially anticonvulsant or antimicrobial agents (Chap. 74). Disseminated *Vibrio vulnificus* infection (Chap. 193) or *ecthyma gangrenosum* due to *Pseudomonas aeruginosa* (Chap. 189) should be considered in immunosuppressed individuals with sepsis and hemorrhagic bullae.

URTICARIA-LIKE ERUPTIONS

Individuals with classic urticaria ("hives") usually have a hypersensitivity reaction without associated fever. In the presence of fever, urticaria-like eruptions are most often due to *urticarial vasculitis* (Chap. 385). Unlike individual lesions of classic urticaria, which last up to 24 h, these lesions may last 3–5 days. Etiologies include serum sickness (often induced by drugs such as penicillins, sulfas, salicylates, or barbiturates), connective-tissue disease (e.g., systemic lupus erythematosus or Sjögren's syndrome), and infection (e.g., with hepatitis B virus, enteroviruses, or parasites). Malignancy, especially lymphoma, may be associated with fever and chronic urticaria (Chap. 72).

NODULAR ERUPTIONS

In immunocompromised hosts, nodular lesions often represent disseminated infection. Patients with disseminated *candidiasis* (often due to *Candida tropicalis*) may have a triad of fever, myalgias, and eruptive nodules (Chap. 240). Disseminated *cryptococcosis* lesions (Chap. 239) may resemble molluscum contagiosum (Chap. 220e). Necrosis of nodules should raise the suspicion of *aspergillosis* (Chap. 241) or *mucormycosis* (Chap. 242). *Erythema nodosum* presents with exquisitely tender nodules on the lower extremities. *Sweet syndrome* (Chap. 72) should be considered in individuals with multiple nodules and plaques, often so edematous that they give the appearance of vesicles or bullae. Sweet syndrome may occur in individuals with infection, inflammatory bowel disease, or malignancy and can also be induced by drugs.

PURPURIC ERUPTIONS

Acute meningococcemia (Chap. 180) classically presents in children as a petechial eruption, but initial lesions may appear as blanchable macules or urticaria. Rocky Mountain spotted fever should be considered in the differential diagnosis of acute meningococcemia. *Echovirus 9 infection* (Chap. 228) may mimic acute meningococcemia; patients should be treated as if they have bacterial sepsis because prompt differentiation of these conditions may be impossible. Large ecchymotic areas of *purpura fulminans* (Chaps. 180 and 325) reflect severe underlying disseminated intravascular coagulation, which may be due to infectious or noninfectious causes. The lesions of *chronic meningococcemia* (Chap. 180) may have a variety of morphologies, including petechial. Purpuric nodules may develop on the legs and resemble erythema nodosum but lack its exquisite tenderness. Lesions of *disseminated gonococcemia* (Chap. 181) are distinctive, sparse, countable hemorrhagic pustules, usually located near joints. The lesions of chronic meningococcemia and those of gonococcemia may be indistinguishable in terms of appearance and distribution. *Viral hemorrhagic fever* (Chaps. 233 and 234) should be considered in patients with an appropriate travel history and a petechial rash. *Thrombotic thrombocytopenic purpura* (Chaps. 72, 129, and 140) and *hemolytic-uremic syndrome* (Chaps. 140, 186, and 191) are closely related and are noninfectious causes of fever and petechiae. *Cutaneous small-vessel vasculitis* (*leukocytoclastic vasculitis*) typically manifests as palpable purpura and has a wide variety of causes (Chap. 72).

ERUPTIONS WITH ULCERS OR ESCHARS

The presence of an ulcer or eschar in the setting of a more widespread eruption can provide an important diagnostic clue. For example, the presence of an eschar may suggest the diagnosis of *scrub typhus* or *rickettsialpox* (Chap. 211) in the appropriate setting. In other illnesses (e.g., anthrax) (Chap. 261e), an ulcer or eschar may be the only skin manifestation.